

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14514

CERTIFICATE OF DEATH

14524

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		e. STREET ADDRESS <u>309 Conococheague St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Frederick</u> Last <u>Banzhoff</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 Year Months <u>10</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Brick Co.</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>George Banzhoff</u>		16. MOTHER'S MAIDEN NAME <u>Annie Poole</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>216-07-1177</u>	
19. INFORMANT <u>Earl Richardson Banzhoff Williamsport Md.</u>		Address <u></u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis Heart Disease</u> DUE TO (b) <u>Subacute Myocarditis</u> DUE TO (c) <u>Obesity Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 weeks</u> <u>15 years</u> <u>40 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis - Arteriosclerosis of the Arteries of Legs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)	
23. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		24. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from <u>Sept 53</u> to <u>Oct 13</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 13</u> , 1967, and that death occurred at <u>1:54 AM</u> , from causes and on the date stated above.			
28. SIGNATURE <u>Dalton M. Welty</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		29. DATE SIGNED <u>Oct. 14, 1967</u>	
30. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>		31. ADDRESS <u>998 Potomac Avenue, Hagerstown, Md.</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>Oct. 15-67</u>	
34. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		35. LOCATION (City or Town) (County) (State) <u>Williamsport Wash. Md.</u>	
36. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>		37. ADDRESS <u></u>	
38. REC'D BY REGISTRAR <u>OCT 17 1967</u>		39. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2522

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108 Locust Avenue, Hagerstown, Md.

14515

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 Hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>449 West Antietam St</b>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH WALKER BARNES</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7 1895</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>14</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Orange, Orange Co Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William M. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Patton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.#1 705-10-6175</b>	
17. INFORMANT <b>Mrs Bessie Barnes</b>		Address <b>449 W. Antietam St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 1954</b> to <b>Oct. 67</b> , that (I) (we) last saw the deceased alive on <b>Oct. 14, 1967</b> , and that death occurred at <b>10/16/67</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks</b>		22b. DATE SIGNED <b>10/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M. D.</b>		22d. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15515

Washington County

Washington County

Washington County

JOSEPH

WALTER

BARRETT

JOSEPH

WALTER

BARRETT

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*Handwritten signature*

Andrew E. Collins Funeral Home Inc

Oct 12 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14516

CERTIFICATE OF DEATH

14526

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>4 Weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1426 Jefferson Blvd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George Junior Frederick Bartlett</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1944</b>
9. AGE (In years last birthday) yrs. <b>22</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tree Surgery</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Charles Town, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George F. Bartlett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fiddler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-46-6131</b>	
17. INFORMANT <b>Mrs Mary F. Bartlett</b>		<b>Charles Town, W.Va</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X Rheumatic heart disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 20, 1967</b> , to <b>17 Oct, 1967</b> , that (I) (we) last saw the deceased alive on <b>16 Oct 1967</b> , and that death occurred at <b>4:24 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Eldon D Hoachlander</b>		22b. DATE SIGNED <b>10/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Eldon D Hoachlander</b>		22d. ADDRESS <b>Hagerstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Maryland</b>
24. FUNERAL DIRECTOR <b>Hagerstown, Md.</b> <b>Andrew K. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 23 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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14517

## CERTIFICATE OF DEATH

14527

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SanMar Md.</b> c. LENGTH OF STAY IN 1b <b>12 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney Keedy Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SanMar Md. Hagerstown</b> d. STREET ADDRESS <b>1320 Hamilton Blvd.</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <b>Alfred S. Bendell Sr.</b>		4. DATE OF DEATH <b>Oct. 14 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city gov.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Albany, N. Y.</b>
13. FATHER'S NAME <b>Moses W. Bendell</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>126-01-6363</b>	
		17. INFORMANT <b>Alfred S. Bendell, Jr. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>177X</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>Chronic hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> to <b>Oct 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 14, 1967</b> , and that death occurred at <b>6:17</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. LeVan</b>		22b. DATE SIGNED <b>10/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		22d. ADDRESS <b>Bloomington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>10-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Rowland Funeral Home, ClearSpring, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

1937

REPORT OF DEATH

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Washington

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FOR STATE HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14518

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14528

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1320 Petersville Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Watkins Bissitt</u>		4. DATE OF DEATH Month Day Year <u>10 20 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-06</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Watkins, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S. Rensberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-42-1511</u>	
17. INFORMANT <u>William W. Wenner</u>		Address <u>Brunswick, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks</u>		22. DATE SIGNED <u>10/20/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Petersville Maryland</u>	
24. FUNERAL DIRECTOR <u>Feste Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 24 1967</u>	

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*Handwritten signature*



14519

## CERTIFICATE OF DEATH

14529

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>30 YRS.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>808 HAMILTON BLVD.</b>				d. STREET ADDRESS <b>808 HAMILTON BLVD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>EDGAR</b> Last <b>BUSEY</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/1914</b>		9. AGE (In years and Birthdays) <b>53</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>INSPECTOR</b>		10b. KIND OF BUSINESS OR <b>AIRCRAFT MFG. CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID E. BUSEY</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE WADDELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>180-01-5416</b>		17. INFORMANT <b>MRS. BARBARA BUSEY</b> <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO <b>cardiovascular</b> (b) <b>General Arteriosclerosis</b> DUE TO <b>General Arteriosclerosis</b> (c) <b>General Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 18, 1967</b> to <b>Oct 29, 1967</b> that (I) (we) last saw the deceased alive on <b>10-9-67</b> 1967, and that death occurred at <b>11:45</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Francisco Rosillo</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>10/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANCISCO ROSILLO</b>			22d. ADDRESS <b>580 Northern Ave. Hagerstown</b>				
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/1/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF DEATH

1-1-30

WASHINGTON

WASHINGTON

FOR HONORABLE SENATE

FOR HONORABLE SENATE

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SENATE

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INSTRUMENT NO. 100

DAVID E. RUSSELL

DAVID E. RUSSELL

NO

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>Hagerstown</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>717 Sunset Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas Morgan Butler</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1901</b>	9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Appliance</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mc Kees Rocks, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William J. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Kezie Burwith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-8103</b>		17. INFORMANT <b>Mrs. Imogene L. Butler, 717 Sunset Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO (b) <b>Cerebral thrombosis</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 19, 1966</b> , to <b>Oct 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 26, 1967</b> , and that death occurred at <b>12:25 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>L. L. Packer Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/27/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. L. Packer Jr.</b>		22d. ADDRESS <b>145 W. Washington St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lappans, Maryland</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14521					14531				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3253 Yosemite Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Martin</u> Last <u>Calaman</u>					4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 22, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arch Brick Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Calaman</u>					14. MOTHER'S MAIDEN NAME <u>Emma Bland</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Melvin A. Calaman</u> Address <u>3253 Yosemite Av. Baltimore, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1967</u> , to <u>Oct 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 1, 1967</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Edson B. Moody</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Oct. 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edson B. Moody</u>					22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tolson Chapel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Maryland</u>		
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>				ADDRESS <u>7 Church St. Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>OCT 10 1967</u>					



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>28 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>153 S. Church St.</u>	
3. NAME OF DECEASED (Type or print) <u>Minerva</u> First <u>Maude</u> Middle <u>Calimer</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife &amp; Clerk</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Newberry's Store</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, R.D. 4 Pa.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>A. Hamilton Snider</u>		15. MOTHER'S MAIDEN NAME <u>Annie E. Stull</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>1929-05-8529</u>		17. SOCIAL SECURITY NO. <u>199-05-8429</u>	
18. INFORMANT <u>Howard E. Calimer</u>		Address <u>153 S. Church St.</u> <u>Waynesboro, Pa.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure.</u> DUE TO (b) <u>Cerebral thrombosis and hemorrhage</u> DUE TO (c) <u>Intraacranial surgery for trigeminal neuralgia.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 22, 1967</u> , to <u>Oct. 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 21, 1967</u> , and that death occurred at <u>8 p.m.</u> from causes on and the date stated above.			
22a. SIGNATURE <u>A. F. Abdullah</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. F. Abdullah</u>		22d. ADDRESS <u>132 N. Potomac, Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/23/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Waynesboro, Franklin, Pa.</u>
24. FUNERAL DIRECTOR <u>Walter J. Grose</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Waynesboro, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 24 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
14523													
14533													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>41 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 211								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>1021 Jefferson Blvd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Elizabeth</u> Last <u>Carbaugh</u>					4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1967</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 28, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co. Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Benjamin Hassler</u>					14. MOTHER'S MAIDEN NAME <u>Mollie Underwood</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Williamsport, Md.</u> <u>Mrs. Herman Leedy 28 Hampton Rd. E.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ENCEPHALOPATHY</u> DUE TO (c) <u>HYPERTENSIVE-ARTERIOSCLEROTIC C-V DISEASE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>7 DAYS</u> <u>Yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIMINISHED MYELINUS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>30 Nov.</u> , 19 <u>66</u> , to <u>19 Oct.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19 Oct</u> 19 <u>67</u> , and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above.													
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>20 Oct. 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>						22d. ADDRESS <u>218 N. Potomac St., Hagerstown, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>					
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel</u>						ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

W. C. Frost

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14524

CERTIFICATE OF DEATH

14534

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hr</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		31-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>48 Madison Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MATTIE LEE CARTER</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22 1892</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housemother</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Stanley Page Co Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Norman</b>		14. MOTHER'S MAIDEN NAME <b>Alice Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>420-18-2230</b>	
17. INFORMANT <b>Amos Stoneberger</b>		Address <b>43 Alexander St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Right femoral artery embolism</b> DUE TO (b) <b>Arteriosclerotic C V Disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Malnutrition, Pulmonary emphysema, diabetic mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 12, 1967</b> , to <b>Oct 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 12, 1967</b> , and that death occurred at <b>7:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L.L. Parker</b>		22b. DATE SIGNED <b>10/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.L. Parker</b>		22d. ADDRESS <b>145 W. Washington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/16/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

127th Avenue, Astoria, Oregon

Mr. J. B. Clark

*Antennaria dioica*, *gutturalis*

Wahrheiten, die in der Natur liegen, sind die einzigen, die uns zu den höchsten Erkenntnissen führen können.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14535

14525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>843 DEWEY AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY SUSAN CEARFOSS</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 14 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 17 1905</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ANTIQUA SHOP</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CNTY MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRISBY SPICKLER</b>		14. MOTHER'S MAIDEN NAME <b>M. ELLEN SHANK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-30-9595</b>	
17. INFORMANT <b>ROBERT K CEARFOSS</b>		18. ADDRESS <b>843 DEWEY AVENUE HAGERSTOWN MD 21740</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding Gastric ulcer</b> 5400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Multiple Myeloma</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(do not know)</del> attended the deceased from <b>Oct. 5, 1967</b> to <b>Oct. 14, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Oct. 14, 1967</b> , and that death occurred at <b>10:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo M. Riego</b>		22b. DATE SIGNED <b>10/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTURO M RIEGO M. D.</b>		22d. ADDRESS <b>119 ANTIETAM ST. HAGERSTOWN MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. TABOR LUTH CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>RURAL CLEAR SPRING MD.</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 19 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14526

CERTIFICATE OF DEATH

14536

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>43 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>924 Preston Road</u>		d. STREET ADDRESS <u>924 Preston Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>NW</u> Last <u>Colley</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sports Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Omaha, Nebr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Colley</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-09-7686</u>	
17. INFORMANT <u>Mrs. Frank Colley</u>		Address <u>924 Preston Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease +</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>25 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adeno Carcinoma Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>67</u> , to <u>Oct 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Sept 25</u> 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Edward W. Ditto, III</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		22b. DATE SIGNED <u>10-5-67</u>	
22d. ADDRESS <u>217 W. Wash. St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Harsh</u>		ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>	
25a. RICH BY REGISTRAR <u>Oct 9</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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OFFICE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14527 CERTIFICATE OF DEATH 14537									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>			75-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>208 West 4 th. St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Cullison</u> Last					4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 9, 1967</u>		9. AGE (In years last birthday) yrs. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard Lee Cullison</u>					14. MOTHER'S MAIDEN NAME <u>Sandra Lee</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>R.L. Cullison 208 W. 4 th. St. Waynesboro, Penna.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Secondary to Prematurity</u> DUE TO (c) <u>(18 weeks gestation)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>10/10/67</u> <u>10:15</u> <u>1967</u> Hour <u>10:15</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/10/67</u> , 19 <u>67</u> , to <u>10/10/67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>10/10/67</u> , and that death occurred at <u>10:15</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>A. M. Mandell</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/10/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>A. M. Mandell, M.D.</u>					22d. ADDRESS <u>301 E. Antietam Street, Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. G. Host</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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DEPARTMENT OF DEATH

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Washington County Hospital

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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14528

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14538

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. LENGTH OF STAY IN lb <b>3 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD 3</b>		d. STREET ADDRESS <b>RFD 3</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Daniel Eugene Deiffenderfer</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-64</b>
9. AGE (In years last birthday) <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Albert J. Deiffenderfer</b>		14. MOTHER'S MAIDEN NAME <b>Dianna Mason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Albert Deiffenderfer, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>9160</b> IMMEDIATE CAUSE (a) <b>Suffocation from smoke in</b> DUE TO (b) <b>Galactem</b> DUE TO (c) <b>Galactem</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stove Exploded - Trapped on Second Floor of Home.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:45 p.m. 10-6-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Smithsburg Wash Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>10-6-67</b>	
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> EXAMINER'S NAME (Type) <b>Edward W. Ditto III, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>217 W. Wash. St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>	23b. DATE THEREOF <b>9-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# FOR STATE HEALTH DEPT.

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VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14529

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14539

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>	c. LENGTH OF STAY IN lb <b>3 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD 3</b>		d. STREET ADDRESS <b>RFD 3</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lee</b> Last <b>Deiffenderfer</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-21-63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>4 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Albert J. Deiffenderfer</b>		14. MOTHER'S MAIDEN NAME <b>Dianna Mason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Albert J. Deiffenderfer, Smithsburg, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation from Smoke in -</b> DUE TO <b>Calculus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>Stove Exploded - trapped on Second floor of Home</b>		
20c. TIME OF INJURY Month, Day, Year <b>9:45 pm 10-6-1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto III, MD</b>		22. DATE SIGNED <b>10-6-67</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, MD</b>		23. LOCATION (City or Town) <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14530

14540

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL 2 HANCOCK MD.</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b> First Middle Last		4. DATE OF DEATH <b>10.</b> Month <b>29..</b> Day <b>19 67</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2.28.1919</b>
9. AGE (In years last birthday) yrs. <b>48</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON COUNTY MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY BARNHART</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE SEAL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 20 9700</b>	
17. INFORMANT <b>MRS SHIRLEY BISHOP</b>		Address <b>RURAL 1 HANCOCK MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO <b>Massive Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Epilepsy + Alcoholism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-8</b> , 19 <b>66</b> , to <b>10-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-26</b> , 19 <b>67</b> ; and that death occurred at <b>6:30 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Charles R Wierer</b>		22b. DATE SIGNED <b>10-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES R WIERER</b>		22d. ADDRESS <b>HANCOCK, Md, Wash</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11.2.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARK HEAD</b>	23d. LOCATION (City or Town) (County) (State) <b>RURAL BIG POOL WASHONGHT MD</b>
24. FUNERAL DIRECTOR <b>Howard F Stone Hancock Md</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 6 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #5, 6, & 7 Film #G493 10/13/67 ph

14531

14541

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>61 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		d. STREET ADDRESS <b>41 W. North Street</b>	
3. NAME OF DECEASED (Type or print) <b>Laura Rachel Dobbins</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1900</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Edward Dangerfield</b>		14. MOTHER'S MAIDEN NAME <b>Caroline White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-14-1011</b>	
17. INFORMANT <b>George Dobbins</b>		Address <b>41 W. North St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-9-67</b> , 19 <b>67</b> , to <b>10-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-5</b> 19 <b>67</b> , and that death occurred at <b>6:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edwin G. Riley</b>		22b. DATE SIGNED <b>10-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin G. Riley, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-10-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR <b>John R. Watson Jr. Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1931

CERTIFICATE OF DEATH

1931

at day

Louis Rachel Robbins  
April 1, 1900 or

Remains of bones

8-9-01 East 10-2-01

10-2-01

Blum 12/12/01

Edwin P. Riley, M.D.

10-2-01  
written and 2nd copy  
Hepburn, 1901



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14532 CERTIFICATE OF DEATH 14542									
1. PLACE OF DEATH a. COUNTY <b>Wash.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Avalon Manor</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>700 Raven Wood Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Jeannette</b> Middle <b>Josephine</b> Last <b>Dorsey</b>					4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-31-1891</b>		9. AGE (In years last birthday) <b>76</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Indian Springs Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Sterling</b>					14. MOTHER'S MAIDEN NAME <b>Josephine Ford</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. Paul Dorsey Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure due to</b> 1551 DUE TO Obstruction, common bile duct due to (b) DUE TO <b>Carcinoma of gall bladder with metastasis to</b> underlying cause last, (c) <b>liver and regional lymph nodes</b>								INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 months</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-27-67</b> , 19 <b>67</b> , to <b>10-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-22</b> , 19 <b>67</b> , and that death occurred at <b>6:05 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John H. Kehne</b> 22c. PHYSICIAN'S NAME (Type) <b>John H. Kehne, M.D.</b>						22b. DATE SIGNED <b>10-27-67</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>1229 Ravenwood Hgts. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-30-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home Hagerstown Md.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>83 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington County Hospital</i>		d. STREET ADDRESS <i>R # 2</i>	
3. NAME OF DECEASED (Type or print) First <i>Maudie</i> Middle <i>Glenn</i> Last <i>Eckstine</i>		4. DATE OF DEATH Month <i>October</i> Day <i>4</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 8, 1879</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Springfield, Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Glenn</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Colliflower</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-54-3830</i>	
17. INFORMANT <i>Mrs. Lottie Blickenstaff</i>		Address <i>R # 2 Smithsburg, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Arteriosclerotic C-V Disease</i> DUE TO (c) <i>Arteriosclerosis, Generalized</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>Yes.</i> <i>Yes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o.m.</i> <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11 Sept</i> , 1963, to <i>Oct 4</i> , 1967, that (I) (we) last saw the deceased alive on <i>Oct 4</i> , 1967, and that death occurred at <i>3:30 P.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>4 Oct. 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. N. FENDEL</i>		22d. ADDRESS <i>218 N. Potomac St. Hagerstown, Md 21740</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/7/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>
24. FUNERAL DIRECTOR <i>W. L. Co. Horst</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE <i>OCT 10 1967</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u> d. STREET ADDRESS <u>974 Lincoln-Way East</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen C. Etchberger</u>		4. DATE OF DEATH Month Day Year <u>10 6 1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. UNDER 1 YEAR Months Days <u>75</u>	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chambersburg-Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel B. Minnick</u>		14. MOTHER'S MAIDEN NAME <u>Mary-C - Lightner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>F. &amp; M. Trust Co. - Chambersburg Penna.</u>		18. ADDRESS <u>20 So. Main St. 17201</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>many years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Bronchitis &amp; Pulmonary Emphysema</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>67</u> , to <u>Oct 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.						
22a. SIGNATURE <u>Edson B. Moody</u>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Edson B. Moody.</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/9/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chambersburg--Franklin--Penna.</u>
24. FUNERAL DIRECTOR <u>ROBERT G. SELLERS</u>		ADDRESS <u>CHAMBERSBURG PA.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14535

CERTIFICATE OF DEATH

14545

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>60 YRS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		21.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>108 CLINTON AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>BELLE</b> Last <b>GABRIEL</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>1</b> Year <b>67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/1884</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mm.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVI HOCH</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN CRAMER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-20-2431</b>	
17. INFORMANT <b>MR. HARVIE F. GABRIEL</b>		<b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>nephrosclerosis</b> DUE TO <b>446X</b> (b) <b>arterosclerosis genit</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/5/67</b> , 19__ to <b>10/1/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>10/1/67</b> , 19__, and that death occurred at <b>9 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. H. Campbell</b> M.D.		22b. DATE SIGNED <b>10/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robt V. H. Campbell</b>		22d. ADDRESS <b>Hagerstown Md</b>	
23a. BURIAL, CREMATION, <b>BURIAL</b>		23b. DATE THEREOF <b>10/4/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION E.U.B. CHURCH</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON CO. MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Normant</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 5 1967</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G393 10/20/67 KK

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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14546

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chambersburg</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>421 W. King St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Rosa Helen Giannoni</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 9, 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>8</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Silver Spring, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lino Giannoni</b>		14. MOTHER'S MAIDEN NAME <b>Rose Tillinghast</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Lino Giannoni, Chambersburg, Penna.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Resp. Obstruction</b> DUE TO (b) <b>Aspiration of vomitus</b> DUE TO (c) <b>Basal skull fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>PASSENGER IN CAR (collision)</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:30</b> p.m. <b>13 Oct 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RT 64 MD. Rock Run Rd</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. N. WEEKS</b>		22. DATE SIGNED <b>556 Northern Rd Hagerstown Md</b>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>	23b. DATE THEREOF <b>10-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14537					14547				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>947 W. Washington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Elmer Carl Gibney</b>			4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1967</b>						
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-91</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ribbon mfg.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George Gibney</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hose</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-1879</b>		17. INFORMANT <b>Edith M. Gibney, Hagerstown, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1810 Broncho pneumonia</b> DUE TO (b) <b>Carcinoma urinary bladder (anaplastic) 6-12 mo.</b> DUE TO (c) <b>with metastases</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <b>John J. Donoghue</b>				22b. DATE SIGNED <b>10-25-67</b>		22c. PHYSICIAN'S NAME (Type) <b>John J. Donoghue</b>			
22d. ADDRESS <b>580 Northern Ave., Hag., Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Washington County Hospital

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501 S. Washington St.

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Washington Co., Mo.

George Oliver

Alison

215-02-1872

Alison, Aggravation, Mo.

John A. Thompson

10-20-57

Aggravation, Aggravation, Mo.

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Alison, Aggravation, Mo.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14538

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14548

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>RFD#1, Keedysville, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rosa Bell Giff</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1908</b>
9. AGE (In years last birthday) yrs. <b>59</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Samples Manor, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Behan Hanes</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Bell Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-5832</b>	
17. INFORMANT <b>Mr. Walter S. Giff</b>		<b>RFD #1, Keedysville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>A. E. W. Ditto, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. E. W. Ditto, Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>10-9-67</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Samples Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>F. Donald Zuckler</b>		25a. RECEIVED BY REGISTRAR <b>Oct 13 1967</b>	
ADDRESS <b>Harpers Ferry, W. Va.</b>		25b. RECEIVED BY SIGNATURE <b>James A. Judge</b>	

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Washington County, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14539

CERTIFICATE OF DEATH

14549

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>16 Mos</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Friendship Manor Nursing Home</b>		e. STREET ADDRESS <b>869 Mulberry Ave</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH AMELIA GILBERT</b>		4. DATE OF DEATH Month Day Year <b>Oct 9 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 7 1883</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William E. Householder</b>		14. MOTHER'S MAIDEN NAME <b>Susan Shugart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-05-6167</b>	
17. INFORMANT <b>Mrs Hilda Long</b>		Address <b>869 Mulberry Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Dis</b> DUE TO (c) <b>8 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carotid Sinus Syndrome</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-24</b> , 19 <b>66</b> to <b>10-9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-9</b> , 19 <b>67</b> , and that death occurred at <b>9:22</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert P. Conrad</b>		22b. DATE SIGNED <b>10-10-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		22d. ADDRESS <b>137 W. Wash Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Waynesboro Pa Franklin Co</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown RFD #3</u>		c. LENGTH OF STAY IN lb <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. James College Road</u>		d. STREET ADDRESS <u>St. James College Road</u>	
3. NAME OF DECEASED (Type or print) First <u>RAY</u> Middle <u>LEO</u> Last <u>GRIFFITH</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4 1906</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Rolla A. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Etta Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-14-7719</u>	
17. INFORMANT <u>Mrs. Martha Sherley Griffith</u>		Address <u>Hagerstown Md. RFD #3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant carcinoid with generalized metastasis</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>23 October 1967</u> , to <u>24 October 1967</u> , that (I) (we) last saw the deceased alive on <u>24 October 1967</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John R. Marsh</u> M.D.		22b. DATE SIGNED <u>10/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John R. Marsh</u>		22d. ADDRESS <u>247 N. Potomac St. Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Wash. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14551

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>9 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>112 SOUTH PROSPECT STREET</b>		d. STREET ADDRESS <b>112 SOUTH PROSPECT STREET</b>	
3. NAME OF DECEASED (Type or print) <b>EUGENE HARRISON GROSS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 6, 1889</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TELEGRAPH OPER. B&amp;O RAILROAD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PAW PAW, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALEXANDER GROSS</b>		14. MOTHER'S MAIDEN NAME <b>NETTIE ZEILER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-05-8035</b>	
17. INFORMANT <b>MRS. EUGENIA G. KNOTT, HAGERSTOWN, MARYLAND.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease &amp; aortic stenosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) ( <del>his hospital</del> ) attended the deceased from <b>4-30, 1952</b> , to <b>10-11, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-18 1967</b> , and that death occurred at <b>3:20 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>John H. Hornbaker</i>		22b. DATE SIGNED <b>10/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. HORNBAKER, M.D.</b>		22d. ADDRESS <b>154 W. WASHINGTON ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>10/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS BURIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, ALLEGANY CO. MD.</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

VR A15 (4)  
20 M 11 86

14542

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14552

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1, Clear Spring</b> c. LENGTH OF STAY IN lb <b>30 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring</b> d. STREET ADDRESS <b>Route 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lloyd # Hastings</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>17</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	9. AGE (In years lost birthday) <b>78</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Mooresville, Md.</b>		13. FATHER'S NAME <b>Thomas Hastings</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>212-03-4186</b>		17. INFORMANT <b>Howard Westurn</b> Address <b>Route 1, Clear Spring Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate with metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>??</b> (c) <b>??</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years ?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Duodenal ulcer with bleeding</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 20</b> , 19 <b>62</b> , to <b>Oct. 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 5</b> , 19 <b>67</b> , and that death occurred at <b>5:45 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Archie Robert Cohen, M.D.</b>		22b. DATE SIGNED <b>10/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22d. ADDRESS <b>Clear Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Blairs Valley Md.</b>
24. FUNERAL DIRECTOR <b>Rowland Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Oct 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Archie Robert Cohen</b>			

10348

CERTIFICATE OF DEATH

10348

John J. [unclear] 30 yrs. [unclear] [unclear]

[unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

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[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

Protestant [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14543

14553

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAVETOWN</b>		211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA WASHINGTON County Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur</b>		First <b>Arthur</b>		Middle <b>LEE</b>		Last <b>Helsley jr</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4 1936</b>	
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		4. DATE OF DEATH <b>OCT 14 1967</b>		Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Lee Helsley</b>				14. MOTHER'S MAIDEN NAME <b>Arlene Kirby</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>KOREAN</b>		17. INFORMANT <b>Fay W Helsley CAVETOWN Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Section 18. fatal abdominal hemorrhage</b> 8214 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>fractured femur</b> DUE TO (c) <b>fractured</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Motorcycle struck rapidly pole</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>7:30 p.m.</b> <b>10-14 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Kelley Highway</b>		20f. (City or town) (County) (State) <b>Smithsburg Wood MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>E.W. Ditto</b>		EXAMINER'S NAME (Type) <b>E. W. DITTO JR. M. D.</b>		22. DATE SIGNED <b>10/15/67</b>		23. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>10/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MASSA WITTEN Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodstock VA.</b>	
24. FUNERAL DIRECTOR <b>CHARLES M ROUZER HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR <b>DACT 19 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>O'Charles Judge</b>			

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-1-68

WASHINGTON

Mr. J. Edgar Hoover

U.S. Department of Justice

WASH DC

Dear Sir:

Re: [illegible]

Very truly yours,

[illegible signature]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>126 Alexander St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Boyle</u> Last <u>Henesy</u>					4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1904</u>		9. AGE (In years last birthday) yrs. <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Organ Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jeremiah Henesy</u>					14. MOTHER'S MAIDEN NAME <u>Eliza Jane Tedrick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-09-2943</u>		17. INFORMANT Address <u>Md.</u> <u>Mrs. B.B. Henesy 126 Alexander St. Hagerstown,</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatitis - regional Metastasis</u> <u>1550</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6-8 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 7</u> , 19 <u>67</u> , to <u>Oct 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 30</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Edward W. Ditto III</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>11-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>					22d. ADDRESS <u>217 W. Washington Street Hagerstown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>					25a. REC'D BY REGISTRAR <u>DATE NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

2357

\* U.S. DEPT. OF AGRICULTURE

*[Faint handwritten signature]*

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>8 Days</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rohrersville</b>		d. STREET ADDRESS <b>211</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>George John Hines</b>		4. DATE OF DEATH Month <b>October</b> , Day <b>19</b> , Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1897</b>	
9. AGE (In years lost birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Locust Grove, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>David Hines</b>		14. MOTHER'S MAIDEN NAME <b>Florence Stine</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>705-07-7750</b>		
17. INFORMANT <b>Mrs. Clark Harwood, Rohrersville, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC LUNG DISEASE, HYPERTENSIVE CARDIOVASCULAR DISEASE</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10/11, 1967</b> , to <b>10/19, 1967</b> that (I) (we) last saw the deceased alive on <b>10/19, 1967</b> , and that death occurred at <b>4:30 A.M.</b> from causes and on the date stated above.				
22a. SIGNATURE <b>R. Amarillo M.D.</b>		22b. DATE SIGNED <b>10/20/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>R. Amarillo M.D.</b>		22d. ADDRESS <b>Sharpsburg Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-22-67</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Rohrersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rohrersville, Md.</b>		
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>ACT 23 1967</b>		
25b. REGISTRAR'S SIGNATURE <b>O'Connell Judge</b>				

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CHRONIC LUNG DISEASE, HYPERTENSIVE CARDIOVASCULAR DISEASE

P. Garza  
10/10/61

Sharpshooting

10/10/61  
10/10/61  
10/10/61



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARLOCK CONVALESCENT HOME</b>		d. STREET ADDRESS <b>92 WEST WASHINGTON STREET</b>	
3. NAME OF DECEASED (Type or print) <b>WILMER EARL HOOVER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JULY 30, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	9. AGE (In years last birthday) yrs. <b>62</b>
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO. MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SILAS M. HOOVER</b>		14. MOTHER'S MAIDEN NAME <b>NANNIE K. SOUDERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO ***</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. ELLEN F. FORSON, BARRINGTON, N.J.</b>		Address <b>217 ALBERTSON AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Multiple Sclerosis. Probable by pathology, Benign</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>6-8</b> , 19 <b>66</b> , to <b>10-13</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10-6-</b> 19 <b>62</b> , and that death occurred at <b>5:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>10/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, III, M.D.</b>		22d. ADDRESS <b>217 W. WASHINGTON ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/16/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASH. CO. MD.</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>OCT 19 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14547

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1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Coffman Home for the Aging</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>514 Washington Square</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SUSAN ELIZABETH HOUSE</b>		4. DATE OF DEATH Month Day Year <b>Oct 27 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1 1873</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Burkettsville Rred Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Bagent</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (No Record)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Ruth Hook</b>		Address <b>21 W. Washington St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis due to arteriosclerosis</b> DUE TO (b) <b>Indefinite</b> DUE TO (c) <b>Indefinite</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic heart disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <b>October 23, 1967</b> , to <b>Oct. 27, 1967</b> , that <u>(1)</u> (we) last saw the deceased alive on <b>Oct. 23, 1967</b> , and that death occurred at <b>4 P. M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>10/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Funkstown Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Funkstown Wash Con Md</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>OCT 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carpal papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 211			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>709 Marshall St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oda Christina Hughes</u>				4. DATE OF DEATH Month Day Year <u>October 1 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 16, 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ridgeley, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carson Harper</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Starks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-24-1864</u>		17. INFORMANT Address <u>Mr. J. M. Hughes 709 Marshall St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of gallbladder</u> DUE TO (b) <u>with metastasis to liver</u> DUE TO (c) <u>1551</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/18/66</u> , 19 <u>66</u> , to <u>10/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/1/67</u> , 19 <u>67</u> , and that death occurred at <u>1025 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Robert V. H. Campbell</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>				22d. ADDRESS <u>Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Norton</u> <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 6 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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REPORT OF DEATH

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>937 Oak Hill Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Selden</u> Last <u>Humphrey</u>		4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Power Co.</u>	9. AGE (In years last birthday) <u>81</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Bellville, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edwin Humphrey</u>		14. MOTHER'S MAIDEN NAME <u>Clara E. Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-5300</u>	
17. INFORMANT <u>Geo. N. Humphrey</u>		Address <u>42 High St. Hingham, Mass.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> stating the underlying cause last. (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1951</u> to <u>Oct. 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27, 1967</u> , and that death occurred at <u>6:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN NAME (Type) <u>Lloyd A. Hoffman</u>		22b. DATE SIGNED <u>10/28/67</u>	
22d. ADDRESS <u>214 N. Potomac St. Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		25a. REC'D BY REGISTRAR <u>Oct 31 1967</u>	
<u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1954

Washington - Army Hospital

Department of the Army

Washington - Army Hospital

Department of the Army

Washington - Army Hospital

Department of the Army

Washington - Army Hospital

Department of the Army

Myocardial Infarction

Acute Ischemic Heart Disease

Oct 11 67

Oct 11 67

W.C. Hunt

Oct 11 1967

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14560

1. PLACE OF DEATH a. COUNTY <b>WASH.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>New York Iron Works</b>				d. STREET ADDRESS <b>833 Maryland Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Franklin</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1943</b>	
9. AGE (In years last birthday) yrs. <b>24</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>		11. BIRTHPLACE (State or foreign country) <b>Clear Spring Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Thomas E. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Mullin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-42-9455</b>		17. INFORMANT <b>Mrs. Elizabeth Johnson</b> Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed skull</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Industrial accident-steel frame fell on victim</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:55xx 10/17 19 67</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) (County) (State) <b>Hagerstown, Wash., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							10/18/67
ACTUAL SIGNATURE <i>Howard N. Weeks</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>580 Northern Ave. Hagerstown, Md.</b>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-20-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 20 1967</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>			



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>		c. LENGTH OF STAY IN lb <b>80 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rfd. 2</b>		d. STREET ADDRESS <b>Rfd. 2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vinton Callie Jones</b>		4. DATE OF DEATH Month Day Year <b>October 18, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1881</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>7 4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lewis Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kauffman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No. --</b>		16. SOCIAL SECURITY NO. <b>217-32-5734</b>	
17. INFORMANT <b>Mrs. Frances Jones, Rfd. 2, Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac</b> DUE TO (b) <b>vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>4221</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1967</b> , to <b>Oct 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 13, 1967</b> , and that death occurred at <b>11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G.W. Hedan</b>		22b. DATE SIGNED <b>Oct 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.W. Hedan</b>		22d. ADDRESS <b>Boonsboro, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10- 20- 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Maryland</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-1-61

RECEIVED

1-1-61





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14552

## CERTIFICATE OF DEATH

14562

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>Route 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Lester Kayser</b>				4. DATE OF DEATH Month Day Year <b>Oct. 20 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/99</b>		9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Animal</b>		11. BIRTHPLACE (Country & State, or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Shields Kayser</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Irvine</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>213-16-0347</b>		17. INFORMANT Address <b>Mrs Gladys Kayser Rd. 4, Hag. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of left middle cerebral artery</b> DUE TO (b) <b>Cerebral atherosclerosis</b> DUE TO (c) <b>atherosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>unk</b> <b>unk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute subacute heart disease with atrial fibrillation; Chronic bronchitis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>13 October, 1967</b> , to <b>20 Oct 1967</b> , that (I) (we) lost the deceased alive on <b>20 October 1967</b> , and that death occurred at <b>10:30 P.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Clovis M Snyder</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>21 October 67</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/23/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blairs Valley Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Clear Spring Md.</b>	
24. FUNERAL DIRECTOR <b>Rowland Funeral Home</b>				25a. REC'D BY REGISTRAR <b>DATE OCT 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

14522

MINISTRY OF DEFENSE

1-10-1941

TO: THE CHIEF OF THE GENERAL STAFF

FROM: THE CHIEF OF THE GENERAL STAFF

SUBJECT: THE CHIEF OF THE GENERAL STAFF

1. The Chief of the General Staff

2. The Chief of the General Staff

3. The Chief of the General Staff

4. The Chief of the General Staff

5. The Chief of the General Staff

6. The Chief of the General Staff

7. The Chief of the General Staff

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9. The Chief of the General Staff

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12. The Chief of the General Staff

13. The Chief of the General Staff

14. The Chief of the General Staff

15. The Chief of the General Staff

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14563

FOR STATE  
HEALTH DEPT.

14553

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>49 FAIRGROUND AVE.</b>		d. STREET ADDRESS <b>49 FAIRGROUND AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY OWENS KING</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/25/1888</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SOFT COAL MINE</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN S. KING</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE JACOBS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>209-09-1319</b>	
17. INFORMANT <b>MRS. NANCY P. KING</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <b>15 yr</b> <b>25 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostate hypertrophy, Benign</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>		22. DATE SIGNED <b>10-6-67</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>		Address (Street, city, town, or county) <b>217 W. Wash. St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, or other disposition of body <b>BURIAL</b>	23b. DATE THEREOF <b>10/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEM. PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>
24. FUNERAL DIRECTOR <b>W.F. Norment Funeral Home</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1967</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-1-63

1-1-63

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

8-288

WASHINGTON

40 WASHINGTON AVE.

40 WASHINGTON AVE.

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

8/27/1988

WASHINGTON

U.S.A.

PENNSYLVANIA

SOFT COAL MINE

WASHINGTON

JEROME JACOBS

JOHN S. KING

WASHINGTON

500-00-1000 MRS. JAMES S. KING

NO

1-1-63

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

14554		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14564	
1. PLACE OF DEATH Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wolfsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				d. STREET ADDRESS 10-2	
3. NAME OF DECEASED (Type or print) Helen Louise Kline		4. DATE OF DEATH Month Day Year Oct 31 1967		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1922	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clarence Weaver			
14. MOTHER'S MAIDEN NAME Anna Metz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Raymond M. Kline, Routel, Smithsburg			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) massive cerebral hemorrhage DUE TO (b) Cerebral Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None				INTERVAL BETWEEN ONSET AND DEATH 3 days 8 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from Aug 1960, to Oct 31, 1967, that (1b) (we) lost saw the deceased alive on Oct 31 1967, and that death occurred at 4:01 M, from causes and on the date stated above.			
22a. SIGNATURE M.E. Byrkit		22b. DATE SIGNED Nov 2, 1967		22c. PHYSICIAN'S NAME (Type) M.E. Byrkit	
22d. ADDRESS Williamsport Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Nov. 3, 1967		23c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery		23d. LOCATION (City or Town) (County) (State) Wolfsville Fred. Md.	
24. FUNERAL DIRECTOR Gladhill Company		ADDRESS Middletown, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

870

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #1d Film #G301 11/6/67 ph

14555

CERTIFICATE OF DEATH

14565

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>10 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hosp.</u>		d. STREET ADDRESS <u>22 West Church St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Mae</u> Last <u>Lamp</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Wash. County</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel H. Fowler</u>	
14. MOTHER'S MAIDEN NAME <u>Rosie E. King</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alvey J. Lamp</u> Address <u>22 W. Church St. Wmpt.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>6 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-8, 1962</u> , to <u>10-26, 1967</u> , that (I) (we) lost the deceased alive on <u>10-26-1967</u> , and that death occurred at <u>3 P.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>John H. Stornaker</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-27-67</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. STORNAKER</u>		22d. ADDRESS <u>154 W. Washington St. Hagerstown - Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Williamsport Wash. Md.</u>
24. FUNERAL DIRECTOR <u>Howard F. Storn</u>		19 ADDRESS <u>177th West Potomac St</u>	25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1955

CLINICAL DATA

1-1-55

Warranted

Prostate

10 days

Williamson

12 West 12th St

Rose

100

camp

100

Female

X

May 22 1955

Hester

Samuel H. Foster

Boice E. King

Miss J. King

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>1 1/2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 6</b> d. STREET ADDRESS <b>Reid</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALMA MARGUERITE LEHMAN</b> First Middle Last 4. DATE OF DEATH <b>October 3 1967</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 10 1926</b> 9. AGE (In years last birthday) <b>41</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Cascade Wash Co Md.</b> 12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Ernest C. Larrabee Sr</b> 14. MOTHER'S MAIDEN NAME <b>Viola Wastler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>---</b> 16. SOCIAL SECURITY NO. <b>217-22-1598</b> 17. INFORMANT <b>Leaster H. Lehman Jr</b> Address <b>Hagerstown R # 6</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of chest</b> DUE TO (b) <b>Carcinoma of breast</b> DUE TO (c) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1 Dec</b> , 19 <b>67</b> , to <b>2 Oct</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2 Oct</b> , 19 <b>67</b> , and that death occurred at <b>7:42</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Elder J Hoachler</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>10/3/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Elder J Hoachler</b> 22d. ADDRESS <b>Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>10/5/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Waynesboro Franklin Co</b>		24. FUNERAL DIRECTOR <b>Hagerstown Md.</b> ADDRESS <b>Andrew K. Coffman Funeral Home Inc</b> 25a. REC'D BY REGISTRAR <b>OCT 9 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>1 week &amp; 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Williamsport</u> 211		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R.F.D.#2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Delores Marie Little</u>				4. DATE OF DEATH Month Day Year <u>October 7 19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1923</u>	
9. AGE (In years last birthday) yrs. <u>44</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Ernest Rawlings, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Boswell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-24-6044</u>				17. INFORMANT <u>Orval T. Little</u> Address <u>R.F.D.#2 Williamsport, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia, Myelocytic</u> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN TWO DEATHS <u>two years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 16, 1965</u> to <u>October 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 7, 1967</u> , and that death occurred at <u>11:20 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Archie Robert Cohen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>October 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				22d. ADDRESS <u>Clear Spring, Maryland 21722</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Williamsport Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf- 7 Church St. Williamsport, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Rfd. 2</b>	
3. NAME OF DECEASED (Type or print) <b>Icie Ellen Ludy</b>		4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1899</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wolfesville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>T. Keller Smith</b>		14. MOTHER'S MAIDEN NAME <b>Clemmie Schroyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Lloyd C. Ludy, Rfd. 2 Myersville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>601X</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease and Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>67</b> , to <b>10-29</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-29</b> 19 <b>67</b> , and that death occurred at <b>4:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Francis E. Rosillo</b>		22b. DATE SIGNED <b>10-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANCIS E. ROSILLO</b>		22d. ADDRESS <b>580 Northern Ave. Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-1-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wolfesville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wolfesville, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>O'Connell Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PR. GEORGES</b> 6104-43 AVE. HYATTSVILLE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE MD</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>				d. STREET ADDRESS <b>6104 43RD AVENUE</b>			
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>MARY</b> Last <b>MAUSER</b>				4. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR 22 1909</b>		9. AGE (In years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OFFICE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE A. MAUSER</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE C. HOHMAN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214 01 8744</b>		17. INFORMANT Address <b>ELIZABETH POHLMAN 16 MADELINE AVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GLIOBLASTOMA, MULTIFORME, BRAIN</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMBOLISM</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <b>10-3</b> , 19 <b>67</b> , to <b>10-9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-9</b> , 19 <b>67</b> , and that death occurred at <b>1:45A</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>Domingo A. Garcia</b>				22b. DATE SIGNED <b>10-9-67</b>		22c. PHYSICIAN'S NAME (Type) <b>DOMINGO A. GARCIA</b>	
22d. ADDRESS <b>1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>OCT 12 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM</b>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <b>MD</b>			
24. FUNERAL DIRECTOR <b>THE DIPPEL BROS INC 7110 BELAIR RD</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MORGAN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8 HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>		d. STREET ADDRESS <b>HOTEL WASHINGTON</b>	
3. NAME OF DECEASED (Type or print) <b>SUE KATHLEEN MCAVOY</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/1891</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>1812B-1741</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MORGAN CO., W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SIEBERT D. SHERRARD</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. STOTLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-20-1714</b>	
17. INFORMANT <b>MRS. MARY B. WHEAT</b>		130 <b>LONG STREET AVE</b> <b>FREDERICKSBURG, VA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute rupture</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. O. Rexrode</b>		22b. DATE SIGNED <b>10/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William O. Rexrode</b>		22d. ADDRESS <b>145 S. Prospect St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HANCOCK PRESBYTERIAN</b>		23d. LOCATION (City or Town) (County) (State) <b>HANCOCK, WASH., MD.</b>	
24. FUNERAL DIRECTOR <b>Richard J. Thorne</b>		25a. REC'D BY REGISTRAR <b>HANCOCK, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 30 1967</b>	

1-10-50

UNIT OF DEATH

1-10-50

WEST VIRGINIA

WASHINGTON

BERKELEY SPRINGS

IN HOUSE

AGE STORY

HOTEL WASHINGTON

WASHINGTON CO. HOSPITAL

OCTOBER 22

NAVY

KATHLEEN

AGE

WINTER

2

WHITE

WASHINGTON

HOUSEWIFE

MARY E. STOTLER

SECRET O. SHERRARD

130 LONGSTREET AVE

21501 1/2 ST. MARY B. HEAT CREDITORS, WASH. DC.

WA

115 . Prospect St. Washington, D.C.

Mr. Allen O. Roberts

HANDOOK PRESIDENTIAL HANDOOK, WASH. DC.

1012307

BURIAL



14571

CERTIFICATE OF DEATH

14561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNA.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>GREENCASTLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ON ARRIVAL WASHINGTON CO. HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Catherine Miller</b>		4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/1907</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co., Penna.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clinton F. Hykes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Oberholzar</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>186-30-7038</b>	
17. INFORMANT <b>Mr. Fred Miller, Greencastle, Penna.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1967</b> , to <b>Oct. 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 27, 1967</b> , and that death occurred at <b>11:30 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>10-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22d. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/27/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Welsh Run Brethern Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Franklin Co., Penna.</b>
24. FUNERAL DIRECTOR <i>[Signature]</i>		25a. REC'D BY REGISTRAR <b>OCT 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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44

still - 1/2 inch

John Work

Copyright

Clinton, N.Y.

1212

7061/12/01

Walter E. Dillman, University

14562

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>340 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>				d. STREET ADDRESS <b>36 ROESSNER Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Stoner</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1885</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>grocery store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John H. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Emma Stoner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-3264</b>		17. INFORMANT Address <b>Mrs. Evelyn Conrad, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>154x</b> IMMEDIATE CAUSE (a) <b>general carcinomatosis</b> DUE TO (b) <b>carcinoma of rectum</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERNAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>13 mos.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>GI Paget's Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Nov. 10</b> , 19 <b>66</b> , to <b>Oct. 16</b> , 19 <b>67</b> , that (1) <del>(he)</del> saw the deceased alive on <b>Oct. 16</b> , <b>1967</b> , and that death occurred at <b>11:45</b> A.M., from causes and on the date stated above							
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Oct. 16, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>				22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10-19-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Tilghmanton, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

# STATE OF NEW YORK

1883

Washington

Washington

Washington

340 days

36 hours per day

36 hours per day

Oct. 12

Miller

John Storer

March 1882

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W

M

1882

Pennsylvania

PROPERTY BROKER

CITY

Emma Storer

John H. Miller

214-09-324

No

March 1882

General Commission

1882

Commission of Record

at Paper's Office

Oct. 12

Nov. 10

Oct. 12

Oct. 12 1882  
Washington, D.C.  
Miller

Victor L. James  
Victor L. James, Jr.

Washington, D.C.

1882-83

1882

1882-83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14563

CERTIFICATE OF DEATH

14573

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>55 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor Nursing Home</u>				d. STREET ADDRESS <u>136 North Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Amiss</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 6, 1901</u>		9. AGE (In years last birthday) yrs. <u>66</u> IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Finishing Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe Organ Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Luray, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Early Moore</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bruffey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>1920-21-22</u>		16. SOCIAL SECURITY NO. <u>214-09-9110</u>		17. INFORMANT Address <u>Thelma Andrews 136 North Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>adenocarcinoma of pancreas with metastasis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>none</u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug '61</u> , 19 <u>  </u> , to <u>Oct 30 '67</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>Oct 1</u> 19 <u>67</u> , and that death occurred at <u>PM</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Harold E. Tritch, Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold E. Tritch, Jr M.D.</u>				22d. ADDRESS <u>302 N. Potomac St Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. A. Hunt</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

1-10-73

1-10-73

22 yrs

14-09-2110

W. C. Hunt

NOV 1981



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14564

14574

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 5 Months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 17 East Salisbury St.				d. STREET ADDRESS 17 East Salisbury St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Grover Eugene Moser				4. DATE OF DEATH Month Day Year Oct. 3rd. 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4th. 1893		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel E. Moser				14. MOTHER'S MAIDEN NAME Mary E. Summers							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dorothy Moser		Address Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia, Bilateral 490X DUE TO 2nd Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Prostatic Hypertrophy, Benign										INTERVAL BETWEEN ONSET AND DEATH 3-5 days 20 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
22. ACTUAL SIGNATURE Edward W. Dittmer				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 10-3-67			
EXAMINER'S NAME (Type) 217 W. Washington St. Hagerstown				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 6, 67		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town or county) (State) St. Paul Wash. Md.		25a. REC'D BY REGISTRAR OCT 6 1967			
24. FUNERAL DIRECTOR Thompson Funeral Home				ADDRESS Clear Spring, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge			

1967

1967

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**ATTENTION FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 21 Film 394 11-7-67 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb <b>46 days.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>209 Humbird St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Dorothy Marie Moss</b> 4. DATE OF DEATH <b>10 26 1967</b> 5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 18, 1913</b> 9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (State or foreign country) <b>Allegany, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>									
13. FATHER'S NAME <b>Henry Brinkman</b> 14. MOTHER'S MAIDEN NAME <b>Katherine woy</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>no</b> 17. INFORMANT <b>Mrs. Katherine Brinkman, Cumberland, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia Secondary</b> (b) <b>Fracture of femur</b> (c) <b>904.0</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>4mons</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell in home</b>				
20c. TIME OF INJURY Month, Day, Year Hour, e.m. <b>6/23/1967</b> ? p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			20f. (City or town) (County) (State) <b>Cumberland, Alleg, Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward W. Dittus III</b> EXAMINER'S NAME (Type) <b>Edward W. Dittus III</b> <b>217 W. Washington St Hagerstown</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
22. DATE SIGNED <b>10-26-67</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Md. Allegany</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>OCT 30 1967</b> 25b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>				

Oct. 29, 1967 Mt. Paran Cemetery

James F. Campbell, Cumberland, Md. - Oct 29 1967

6/8 61 ✓ Home Cumberland, Md. 4/19 61  
Fall in home

Fracture of femur  
Lobular pneumonia  
Harris

Mrs. Katherine Brinkman, Cumberland, Md.  
Mother

Henry Brinkman  
Katherine wife

Can Home

Citizens, many lost

Nov. 18, 1913 61  
Mass 10 26 61  
209 Humboldt St.

4-6 days  
Cumberland  
Maryland  
Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

14568

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14576

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 1/2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>177 Manse Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Russell</b> Last <b>Mowry</b>				4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-15</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>21</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>steel fabricati.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Derry, Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William R. Mowry</b>				14. MOTHER'S MAIDEN NAME <b>Dora Richardson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Geraldine Mowry, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis of Coronary Arteries</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>none</b> <b>2 1/2 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1/65</b> , 19 <b>65</b> , to <b>10/21</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/13</b> , 19 <b>67</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>William O. Rexrode</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William O. Rexrode</b>				22d. ADDRESS <b>1455 Prospect St.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10-23-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Coles Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Derry, Penna.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

10-2-57

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

10-2-57



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

14567

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14577

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>FRANKLIN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Clearspring, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLUMBUS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>133 So. WARREN</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dolores</u> First <u>NMN</u> Middle <u>Neighbors</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-50</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>WAITRESS</u>	
11. BIRTHPLACE (State or foreign country) <u>COLUMBUS, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Ralph Neighbors</u>		14. MOTHER'S MAIDEN NAME <u>CLARA OSBURN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RALPH NEIGHBORS</u>		Address <u>COLS. Ohio</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Depressed Skull fracture c</u> <u>8161</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Brain Stem Injury</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in Rt. Rear Seat Auto which Struck Truck</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1230</u> p.m. <u>10-7 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>IS 70</u>		20f. (City or town) (County) (State) <u>W. Clearspring Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
217W. Washington St		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>10-7-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MILES CEM.</u>		23d. LOCATION (City, town or county) (State) <u>Putland Ohio</u>	
24. FUNERAL DIRECTOR <u>Jerry Spears</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1967</u>	
ADDRESS <u>Columbus, Ohio</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1907

REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1907

ALBANY:  
J.B. LEECH, PRINTERS  
1907

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1907

REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
JANUARY 1, 1907

ALBANY:  
J.B. LEECH, PRINTERS  
1907

14568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14578

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #1</u>		c. LENGTH OF STAY IN lb <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Falling Waters Road</u>		d. STREET ADDRESS <u>Falling Waters Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>HENRY</u> Last <u>NEWLIN, SR.</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1929</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Enoch Newlin</u>	
14. MOTHER'S MAIDEN NAME <u>Marie Clem</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-28-5744</u>		17. INFORMANT <u>Gladys Newlin</u> Address <u>Williamsport RFD #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Laceration</u> DUE TO (b) <u>Basal fracture of skull</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture left tibia + fibula; Chest injuries</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) <u>Motorcycle in head on collision with car</u>	
20c. TIME OF INJURY Hour <u>12:05</u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u>Oct 22 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Williamsport Washington Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John A. Moran</u> M.D. EXAMINER'S NAME (Type) <u>JOHN A. MORAN</u>		22. DATE SIGNED <u>10/23/67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>215W. Washington St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Williamsport, Wash. Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u> ADDRESS <u>Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12508

1133

WORLD'S WARREN RECORDS OF 1911

12508 1133

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14579

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Antietam</u>		d. STREET ADDRESS <u>Antietam</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Floyd Cecil Pierce Sr.</u>		4. DATE OF DEATH Month Day Year <u>Oct. 25 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11 1929</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>3 13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plastic Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George T. Pierce</u>		14. MOTHER'S MAIDEN NAME <u>Effie V Ely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes World War #2</u>		16. SOCIAL SECURITY NO. <u>218 24 9595</u>	
17. INFORMANT <u>Mrs. Hazel A. Pierce</u>		Address <u>Antietam Sharpsburg Md.</u> RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage from</u> <u>1919</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>broken of Squamous Cell carcinoma</u> DUE TO (c) <u>into pulmonary vessels</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15-30 hrs.</u> <u>6-12 Mts.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>10-26-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>217 W. Washington St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Washington Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
6M 1/66

14570

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14580

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>60 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>302 N. Cannon Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>George Dewey Pike</u>		4. DATE OF DEATH <u>October 8 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pattern Maker</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin County, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel J. Pike</u>		14. MOTHER'S MAIDEN NAME <u>Ida C. Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6607</u>	
17. INFORMANT <u>Chas. J. Pike</u>		Address <u>217 N. Cleveland Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractured Ribs, Right Chest With Hemo-</u> DUE TO <u>Pneumothorax</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Multiple Fractures Of Pelvis With Pelvic Retroperitoneal Hemorrhage</u> (c) <u>Fractured Right Leg (Tibia and Fibula)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Struck by automobile while crossing street.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7:20 p.m. 10-6- 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Street</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Hagerstown, Washington, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-9-67</u>	
		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Host</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

W. C. Hunt

## CERTIFICATE OF DEATH

14571

14581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithsburg</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Luther</u> Last <u>Plank</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>March 11, 1904</u>		9. AGE (In years last birthday) yrs. <u>63</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Locomotive Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gettysburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Roy Plank</u>				14. MOTHER'S MAIDEN NAME <u>Virgie May Plank</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-7654</u>		17. INFORMANT <u>Mrs. Ruth M. Plank R # 2 Smithsburg, Md.</u>		Address <u>Holiday Acres</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rt hemiplegia</u> DUE TO (c) <u>Acute cerebral vascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity &amp; hypertension; diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>none</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 14</u> , 19 <u>66</u> , to <u>Oct 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 19</u> 19 <u>67</u> , and that death occurred at <u>P. M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold R. Tritch, Jr M.D.</u>				22d. ADDRESS <u>302 N. Potomac St. Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Wm. C. Wood

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14572

CERTIFICATE OF DEATH

14582

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY in lb <b>43 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>224 N. POTOMAC ST.</b>		d. STREET ADDRESS <b>224 N. POTOMAC ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSHUA</b> Middle <b>POFFENBERGER</b> Last <b>POFFENBERGER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/1901</b>
9. AGE (In years birth day) yrs. <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>BOOKBINDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLISHING CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSHIA POFFENBERGER</b>		14. MOTHER'S MAIDEN NAME <b>MARIA RENNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-1201</b>	
17. INFORMANT Address <b>MRS. JEAN GETTEL HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 29, 1966</b> to <b>Oct 29, 1967</b> that (I) (we) lost saw the deceased alive on <b>Oct 21, 1967</b> and that death occurred at <b>2 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Novenstein</b>		22b. DATE SIGNED <b>10-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		22d. ADDRESS <b>FUNKSTOWN MD</b>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>11/1/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City or town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 2 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

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CERTIFICATE OF DEATH

14583

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>35 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>RD 2</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Marie Portner</b>		4. DATE OF DEATH Month Day Year <b>Oct. 4 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-16-1922</b>
9. AGE (In years last birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Guy Manahan</b>		14. MOTHER'S MAIDEN NAME <b>Jennie A. Willard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-58-9531</b>	
17. INFORMANT <b>Lee F. Portner</b>		Address <b>Thurmont, Md. RD 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brondhogenic carcinoma with generalized metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-8, 1956</b> , to <b>10-4, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-4 19 67</b> , and that death occurred at <b>9:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles F. Hess</b>		22b. DATE SIGNED <b>10-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>		22d. ADDRESS <b>Smithsburg, Maryland 21783</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Raymond E. Croager</b>		25a. REC'D BY REGISTRAR <b>Thurmont, Md. OCT 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-1-1961

STATEMENT OF DATA

1-1-1961

1-1-1961

1-1-1961

## CERTIFICATE OF DEATH

14574

14584

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>113 BROADWAY</b>			
3. NAME OF DECEASED (Type or print) First <b>MAYMIA</b> Middle <b>MARIE</b> Last <b>POWERS</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/07/09</b>	
9. AGE (In years last birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>MEALLY KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>GROVER MUSIC</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>402-64-7794</b>		17. INFORMANT <b>EDWARD J POWERS HAGERSTOWN MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> DUE TO (b) <b>Multiple small pulmonary emboli</b> DUE TO (c) <b>Perforance of gastro-duodenostomy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>my husband</del> ) attended the deceased from _____, 19____, to _____, 19____, that (I) ( <del>we</del> ) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Thomas V Craig</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS V CRAIG M. D.</b>				22d. ADDRESS <b>247 N POTOMAC ST. HAGERSTOWN MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U.S. GOV'T CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>GETTYSBURG PENNA.</b>	
24. FUNERAL DIRECTOR <b>CHARLES M ROUZER HAGERSTOWN MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 19 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14585

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>9 wks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>R. D. 3</b>	
3. NAME OF DECEASED (Type or print) <b>Emma C. Ridenour</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1879</b>
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abram Weddle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Stouffer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-36-6947B</b>	
17. INFORMANT <b>Mr. David M. Ridenour</b>		Address <b>Smithsburg #3, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO (b) <b>Fracture Of Right Femur</b> DUE TO (c) <b>Arteriosclerotic Cardio Vascular Disease.</b> Several years INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Fell in her home.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>?</b> p.m. <b>8-8</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Smithsburg, Washington, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		22. DATE SIGNED <b>10-13-67</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		Address (Street, city, town, or county) <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>10/15/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithsburg, Washington, Md.</b>	
24. FUNERAL DIRECTOR <b>Waynesboro, Penna.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Washington

State

Washington Co. Hospital

State

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X

Female - White

Housewife

Married

Henry Alice Gaudier

215-38-5975 Mr. David M. Gaudier, 1, M.

Washington

Washington

Director of State Police

Washington State Police, Olympia, Wash.

State Police

Washington State Police, Olympia, Wash.

1975

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Washington State Police

Washington State Police, Olympia, Wash.

Washington State Police



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14576

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14586

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		d. STREET ADDRESS <b>Homewood church Home</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MILDRED MARY ROEDIGER</b>		4. DATE OF DEATH Month Day Year <b>Oct 14 1967 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 3 1885</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>St Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob C. Roediger</b>		14. MOTHER'S MAIDEN NAME <b>Emma C. Oldendolph</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>345-10-5061 A</b>	
17. INFORMANT <b>Rev Mark Wagner Homewood Church Home</b>		Address <b>Williamsport Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture Of Femur</b> DUE TO (c) <b>Arteriosclerotic Cardio Vascular Disease. Several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>14 days</b> <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Misstepped from building onto pavement.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:30 9-30- 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Hagerstown, Washington, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		22. DATE SIGNED <b>10-14-67</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Uoffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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WASHINGTON, D.C. 20540

U.S. DEPARTMENT OF JUSTICE

WASHINGTON COUNTY, MARYLAND

WILMINGTON, MARYLAND

DATE: OCT 1 1981

RE: [illegible]

U.S. DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14577

14587

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. LENGTH OF STAY IN lb <b>31 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>29 South Main St.</b>				d. STREET ADDRESS <b>29 South Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alene</b> Middle <b>Moore</b> Last <b>Schultz</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1892</b>	9. AGE (In years last birthday) yrs. <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hammonton, N. J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Willits</b>				14. MOTHER'S MAIDEN NAME <b>Imogene Crowley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. R. G. Schultz, Smithsburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350X Acute pulmonary E of pneumonia</b> DUE TO (b) <b>Parkinson's disease</b> DUE TO (c) <b>Arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>15 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 14, 1967</b> to <b>Oct 18, 1967</b> that (I) (we) last saw the deceased alive on <b>Oct 18, 1967</b> and that death occurred at <b>8 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Geo. A. Kohler</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Geo. A. Kohler</b>				22d. ADDRESS <b>Smithsburg</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Smithsburg Washington Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home., Smithsburg, Md.</b>				25. REC'D BY REGISTRAR <b>OCT 23 1967</b>		26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14578

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14588

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>W. Virginia</u> b. COUNTY <u>Jefferson</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sandy Hook</u>		c. LENGTH OF STAY IN lb <u>3-4 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>RFD 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>(NHN)</u> Last <u>Seaman</u>		4. DATE OF DEATH Month <u>Approx. 10</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-12-15</u>
9. AGE (In years last birthday) yrs. <u>52</u>		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>body shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Oak Hill, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Seaman</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Weinstanley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>077-01-6946</u>	
17. INFORMANT <u>Mrs. Earl Toney, Wilmington, Dela.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents.</u> DUE TO <u>Massive Fracture left Temporal Bone &amp; Zygomatic Process &amp; Laceration of Left Temporal lobe &amp; Subdural Hematoma.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 12 Min. to 2 hrs.</u> <u>Approx. 2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from small Embankment into Rocky Stream bed</u>	
20c. TIME OF INJURY Month, Day, Year <u>App. 10-26-1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Rural Road</u>		20f. (City or town) (County) (State) <u>Sandy Hook Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>10-30-67</u>	
ACTUAL SIGNATURE <u>Edward W. DiHo III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>217 W. Washington St. Hagerstown Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wilmington, Dela.</u>	
24. FUNERAL DIRECTOR <u>Minnech Funeral Home, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

1944

Virginia

August 1944

John

White

August 1944

August 1944

August 1944

August 1944

August 1944

August 1944

August 1944

August 1944

August 1944

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August 1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14579

14589

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>	
c. LENGTH OF STAY IN 1b <b>24 mo.</b>		d. STREET ADDRESS <b>4824 EASTERN LANE, SUITLAND MD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PHYLLIS</b> Middle <b>M.</b> Last <b>SEBENS</b>		4. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-18-12</b>
9. AGE (In years lost birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>FRANK COOPER</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE BROOKS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO *****</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>MRS. FLORENCE COOPER, VANDALLIA, MICHIGAN</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AMYOTROPHIC LATERAL SCLEROSIS</b> 3561 DUE TO (b) <b>2 YRS, 7 MOS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-25</b> , 19 <b>65</b> , to <b>10-7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-7</b> , 19 <b>67</b> , and that death occurred at <b>10:40 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Domingo A. Garcia</b>		22b. DATE SIGNED <b>10-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DOMINGO A. GARCIA</b>		22d. ADDRESS <b>1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>10/8/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>POES CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CASS CO. MICHIGAN</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>OCT 10 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1933

STATE OF TEXAS

1933

REGISTERED

CHARTER

REGISTERED

REGISTERED AND STATE NOTARY

REGISTERED

AND REGISTERED OFFICE, VARIOUS, REGISTERED

REGISTERED

REGISTERED AND STATE NOTARY

REGISTERED

1933

1933

1933

CHARLES N. LOUIS, BARRISTER, REGISTERED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14590

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14590

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>56 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>200 Pangborn Blvd.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>200 Pangborn Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Myrtice</b> Last <b>Settles</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1967</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-30-91</b>		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Warren Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Aureluis Lawson</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Jennings</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>James D. Settles, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic mellitus &amp; diabetic neuropathy</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>1 day</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1962</b> to <b>Oct. 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 12, 1967</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Edson B. Moody</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edson B. Moody</b>				22d. ADDRESS <b>145 S. Prospect St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-20-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>OCT. 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1930

NEW STATE OF TEXAS

1930

Registration

Harrodsburg 20 years  
200 Harrodsburg Blvd.

Female white  
2-22-01

Harrodsburg  
Austin's Lawson

James D. Bellows, Harrodsburg, Mo.

*Check with - with receipt*  
*Return to West Union*  
*and Harrodsburg*

*Oct 1, 1931*  
*Chubb*  
*for 1931*

19-20-01

Oct 20 1931

## CERTIFICATE OF DEATH

14591

14581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>xxxx Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		d. STREET ADDRESS <b>312 Eldrid Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Marie Louise Shand</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine Nat'l. Library of</b>	9. AGE (In years last birthday) yrs. <b>43</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Paul Pringre</b>		14. MOTHER'S MAIDEN NAME <b>Jeanne Eisenbach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Fred E. Shand</b>		Address <b>312 Eldrid Drive Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> 331X DUE TO (b) <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week 1 1/2 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-23</b> , 19 <b>67</b> , to <b>10-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-5</b> , 19 <b>67</b> , and that death occurred at <b>12:20 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Edwin G. Kiley</b>		22b. DATE SIGNED <b>10-5-67</b>	22c. PHYSICIAN'S NAME (Type) <b>Edwin G. Kiley</b>
22d. ADDRESS <b>Western State Hospital, Hagerstown, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Md.</b>
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>4834 Georgia Avenue</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>OCT 9 1967</b>		DATE <b>OCT 9 1967</b>	

1934

1934

Marie Louise Shand

10

2

2

Cerebral vascular accident 1/24/34  
lobular pneumonia

Blount, Riley

10-2-34

6-23

10-2-34

10-2-34

10-2-34



TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar or to burial-transit permit. File pages 3 and 4 with the registrar or to burial-transit permit. or removal.

VS. A15ME(S)  
SM 9/55

14582

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sharpsburg</u>		c. LENGTH OF STAY IN TB <u>Minutes</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg, Md.</u>		2/-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 65- Auto accident</u>		d. STREET ADDRESS <u>112 S. Mechanic St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Isaiah</u> Middle <u>Irvin</u> Last <u>Sheffler</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1944</u>
9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finishing &amp; Dye Co. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Sheffler</u>		14. MOTHER'S MAIDEN NAME <u>Rayetta (last name not known)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-44-3169</u>	
17. INFORMANT <u>Vickie A. Sheffler</u>		Address <u>Sharpsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Laceration</u> <u>8194</u> DUE TO <u>Fracture of base of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>"</u> (c) <u>"</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>Instant</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile struck guard rail on a curve</u>	
20c. TIME OF INJURY Hour <u>4:05</u> P. M. <u>10/23/1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Sharpsburg Washington Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John A. Moran M.D.</u>		DATE SIGNED <u>10/23/67</u>	
EXAMINER'S NAME (Type) <u>JOHN A. MORAN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24, 1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct 24 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairplay</u>	
c. LENGTH OF STAY IN lb <u>11 da's.</u>		d. STREET ADDRESS <u>At</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Md. 154 N. Artizan St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Magdalene Shervin</u>		4. DATE OF DEATH <u>October 22 1967</u>	
5. SEX <u>fe</u> 6. COLOR OR RACE <u>wh.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 23, 1883</u> 9. AGE (In years lost birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Co</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Underwood</u>		14. MOTHER'S MAIDEN NAME <u>Anna Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Labe Linnell M. Williamsport Md</u> Address <u>30 Tammany Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>Atherosclerotic Cardiovascular disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mins</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>M. Byrkit</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. Byrkit, M. D.</u>		22d. ADDRESS <u>Williamsport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 25 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASH CO MD</u>	
24. FUNERAL DIRECTOR <u>John N. Bart</u> ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 26 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14584

CERTIFICATE OF DEATH

14594

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1905 KNOTTY PINE DR.</b>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>SHIELDS SR.</b> Last		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/1895</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINERY MFG.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NOTH IRELAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED SHIELDS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET McMULLEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>150-03-7997</b>	
17. INFORMANT <b>MRS. HELEN SHIELDS MD.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest - Secondary to</b> DUE TO (b) <b>Enter abdominal Hemorrhage from</b> DUE TO (c) <b>ruptured aortic aneurysm</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>45 min</b> <b>18-20 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 28</b> , 19 <b>67</b> , to <b>OCT 29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>OCT 29</b> , 19 <b>67</b> , and that death occurred at <b>8:10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto, III, M.D.</b>		22b. DATE SIGNED <b>10-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>		22d. ADDRESS <b>217 W. Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, <b>BURIAL</b>		23b. DATE THEREOF <b>10/31/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Norment Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

VR A15 (4)  
25M 1/67





14585

CERTIFICATE OF DEATH

14595

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG POOL MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY MARGARET SHIVES</b>		4. DATE OF DEATH Month Day Year <b>10 26 19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 6. 1906</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON COUNTY MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM E BEARD</b>		14. MOTHER'S MAIDEN NAME <b>MARY M MILLS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALFRED E SHIVES BIG POOL MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary artery atherosclerosis with occulison</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertension</b> (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <b>10/25/67</b> , 19__, to <b>10/26/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>10/26/67</b> , 19__, and that death occurred at <b>6:35 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED <b>Oct. 27. 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>		22d. ADDRESS <b>Clear Spring, Md. 21722</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10.28.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARK HEAD</b>	23d. LOCATION (City or Town) (County) (State) <b>BIG POOL WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <i>Howard H. Stone</i>		25a. REC'D BY REGISTRAR <b>NOV 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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10583

WASHINGTON

MARYLAND

WASHINGTON

BIG ROCK MARYLAND

IS MR.

WASHINGTON

WASHINGTON COUNTY CAPITAL

10 20 30

MARY JANE SHIVERS

1000.0.1900

WASHINGTON COUNTY 10 U.S.A.

SAME

WASHINGTON

MARY J. SHIVERS

WASHINGTON

ALFRED E. SHIVERS - BIG ROCK MD.

NAME

Washington

Washington County, Md. - 1000.0.1900

Washington

*John Robert Gentry*

John Robert Gentry, M.D.

Chas. Spring, Md. 2177

BIG ROCK MARYLAND

10.02.37

10.02.37

Washington County, Md. 1000.0.1900

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

14586

14596

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>212 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Victor Smith</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT MFG.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Smith</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Meats</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-6865A</b>	
17. INFORMANT <b>BOX 25 Address MR. PAUL V. SMITH, SMITHSBURG, MARYLAND.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cor pulmonale</b> <b>5271</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>(1) Arteriosclerotic Heart Disease (2) Arteriolosclerotic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>MARCH 23, 1967</b> to <b>OCT. 1, 1967</b> , that (1) (we) saw the deceased alive on <b>OCT. 1, 1967</b> , and that death occurred at <b>3:23 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. DATE SIGNED <b>OCT. 2, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNTAIN VIEW CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>SHARPSBURG, WASH. CO. MD.</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles M. Rouzer</b>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10583

CERTIFICATE OF DEATH

515 day Hospital  
513 Poppy Street

Charles Victor Smith

Dec. 20 1952

Washington County, Md.

20000 Mch 2

William Smith

for Pulmonary

Pulmonary emphysema

On Certificate of Death (Certificate of Death)

March 23 1953

Oct. 11 1952

Victor L. James, M.D.

Victor L. James, M.D.

CHARLES H. JAMES, M.D., HARRISBURG, PENNSYLVANIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14587

CERTIFICATE OF DEATH

14597

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>		c. LENGTH OF STAY IN 1b <u>25 Yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>123 W. Main Street</u>		d. STREET ADDRESS <u>123 W. Main Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLIFTON LUTHER SMITH</u>		4. DATE OF DEATH Month Day Year <u>Oct. 16 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1911</u>
9. AGE (In years lost birthday) yrs. <u>56</u>		10. IF UNDER 1 YEAR Months Days <u>2 17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operations Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Eakles Mills Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Clarence L. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Gay Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-1063</u>	
17. INFORMANT <u>Mrs. Mary C. Smith</u>		18. ADDRESS <u>123 W. Main St.. Sharpsburg Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30DDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 25, 1966</u> to <u>Sept 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 15, 1967</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rizalito Amarillo</u>		22b. DATE SIGNED <u>10/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RIZALITO AMARILLO</u>		22d. ADDRESS <u>Sharpsburg, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg, Washington Md.</u>
24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 20 1967</u>	
ADDRESS <u>7 Church St. Williamsport Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1958

RECEIVED

1958

DIABETES MELLITUS

CONVULSIONS

1958

Butler  
Pizarro Ruelas

10/17/58  
Charlottesville  
10/17/58

OCT 20 1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14588

CERTIFICATE OF DEATH

14598

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 hr</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY WILLIAM SMITH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>20</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Wash. Cty., Md. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>No Record</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-1762A</b>	
17. INFORMANT <b>Mrs. Virginia McClelland</b>		Address <b>50 E. Antietam St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Hypertensive cardiovascular disease with congestive failure</b> DUE TO (c) <b>Indefinite</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 20 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>7:50P.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>October 7, 1967</b>		20f. (City or town) (County) (State) <b>October 7, 1967</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>October 7, 1967</b> , to <b>October 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 7, 1967</b> , and that death occurred at <b>7:50P.</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>10/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

11382

Washington

Washington

1st

Washington County Hospital

50 East Franklin St.

HARRY

WILLIAM

Oct 27

Miss White

414-38-1784

Notice

Washington, D.C.

Notice

Notice

no

Notice

1st

October 2, 1967

October 2, 1967

7:50

R. H. Kneafsey, D.D.

Washington, D.C.

10/10/67

Harry E. Green

Washington, D.C.

Agency K. Collins

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14589

14599

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>				d. STREET ADDRESS <u>20 EAST WASHINGTON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>REBECCA</u> Last <u>SPIELMAN</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 5, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPARTMENT STORE</u>		11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN, MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES D. BURNETT</u>				14. MOTHER'S MAIDEN NAME <u>LILY RANDALL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-14-2745</u>		17. INFORMANT <u>MISS DORIS I. BURNETT, HAGERSTOWN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Subcapital fracture Femur</u> <u>4500</u> DUE TO (b) <u>Advanced Atherosclerosis, generalized</u> DUE TO (c) <u>+ Atherosclerotic Heart Disease &amp; Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from bed at Nursing home.</u>					
20c. TIME OF INJURY Month, Day, Year <u>6:00 p.m. 10/16/1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) (County) (State) <u>N. Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>		22. DATE SIGNED <u>10/30/67</u>					
EXAMINER'S NAME (Type) <u>EDWARD W. DITTO, III, M.D.</u>		Address (Street, city, town, or county) <u>217 W. WASH. ST. HAGERSTOWN, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>10/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MD.</u>		ADDRESS <u>HAGERSTOWN, MD.</u>		25. RECEIVED BY REGISTRAR <u>NOV 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Film #394- 11/3/67 - Originally reported on  
regular certificate and should have been on H.E.

WB.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14530											
14600											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b> d. STREET ADDRESS <b>8 TALIFERRO ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>OTIS WINFRED STANLEY</b>					4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>15</b> Year <b>19 67</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/24/1910</b>		9. AGE (In years lost birthday) yrs. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCKING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PAGE COUNTY, VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>HARVEY ALFRED STANLEY</b>					14. MOTHER'S MAIDEN NAME <b>HETTE MAUDE EPPARD</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-14-6541</b>		17. INFORMANT <b>8 TALIFERRO ST. MARTHA E. STANLEY HANCOCK, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) <b>Appendiceal abscess</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10/10/67</b> , 19 <b>67</b> , to <b>10/15/67</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that death occurred at <b>10/15/67</b> M, from causes on and on the date stated above.											
22a. SIGNATURE <b>John R. Marsh</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/16/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. John R. Marsh</b>					22d. ADDRESS <b>247 N. Potomac St. Hagerstown, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. THOMAS EPISCOPAL</b>			23d. LOCATION (City or Town) (County) (State) <b>HANCOCK WASH., MD.</b>				
24. FUNERAL DIRECTOR <b>Howard F. Stone</b>					ADDRESS <b>HANCOCK, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10520

DEPARTMENT OF HEALTH

WASHINGTON

MARYLAND

WASHINGTON

HANDSON

11 DAYS

HANDSON

9 TALLERD ST.

WASHINGTON COUNTY HOSPITAL

STANLEY

WHITE

OTIS

X

10/2/1910

WHITE

MALE

PAGE COUNTY, VIRGINIA, U.S.A.

TRUCKING

TRUCKING

NETTE MAUDE EPPARD

WAMEY ALFRED STANLEY

9 TALLERD ST.

10520-10521 VARIOUS ST. STANLEY HANSON, MD.

ST. THOMAS EPISCOPAL HANCOCK WASH. DC.

10520 10521

HANCOCK, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>920 Hamilton Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Louise</u> Last <u>Starr</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1878</u>
9. AGE (In years last birthday) yrs. <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Bitzell Cobb</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Kansler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-0932A</u>	
17. INFORMANT <u>Mrs. John P. Coblentz</u>		Address <u>801 Rolling Road, Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>332X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 8, 1961</u> , to <u>Oct. 7, 1967</u> , that (we) last saw the deceased alive on <u>Oct. 6, 1967</u> , and that death occurred at <u>5:20 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>10/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>Oct 11 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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*[Signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14592					14602						
1. PLACE OF DEATH a. COUNTY <i>Washington</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>West Virginia</i> b. COUNTY <i>Berkeley</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>			c. LENGTH OF STAY IN 1b <i>1 yr. 5 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Inwood, Box 52</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Williamsport Sanitarium</i>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Julia Lee Staub</i>			4. DATE OF DEATH Month Day Year <i>Oct 13 1967</i>								
5. SEX <i>F</i>		6. COLOR OR RACE <i>Wh</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 30 1883</i>		9. AGE (In years last birthday) <i>84 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired teacher</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Public School</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Wh. Va.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>			
13. FATHER'S NAME <i>George William Hill</i>					14. MOTHER'S MAIDEN NAME <i>Anna Virginia Reynolds</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>		17. INFORMANT <i>Ruth Bomsher Williamsport Md.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Atherosclerotic Cardiovascular disease</i> DUE TO (c) <i>10 yrs</i>										INTERVAL BETWEEN ONSET AND DEATH <i>mins</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <i>April 1, 1966</i> to <i>Oct 13, 1967</i> , that (1) (we) last saw the deceased alive on <i>Oct 19 1967</i> , and that death occurred at <i>802</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>M.E. Bynkit</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Oct 13</i>				
22c. PHYSICIAN'S NAME (Type) <i>M.E. Bynkit</i>					22d. ADDRESS <i>Williamsport Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-15-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>MARTINSBURG W.VA.</i>				
24. FUNERAL DIRECTOR <i>Edward K Brown</i>					ADDRESS <i>Martinsburg W.Va</i>		25a. REC'D BY REGISTRAR <i>OCT 16 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

Report of the  
Commissioner of Health  
on the  
State of the  
Public Health  
in the  
District of Columbia  
for the  
Year 1902

Published by  
the  
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Washington, D. C.  
1903

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the  
Commissioner of Health  
at the  
Department of Health  
Building, Washington, D. C.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

14593				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14603			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro, R #1</b> d. STREET ADDRESS <b>Toms Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>OSCAR FRANCIS STONER</b>				4. DATE OF DEATH <b>Oct 23 1967</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 4 1920</b>					
9. AGE (In years lost birthday) <b>47 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driven</b>				10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Oscar H. Stoner</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Florence</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-10-3331</b>		17. INFORMANT <b>Mrs Mildred J. Stoner</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock - Secondary to Massive Blood Loss</b> DUE TO (b) <b>Due - Perforation Stomach - Caecum</b> DUE TO (c) <b>of Superior Mesenteric Artery + laceration of Abdominal Aorta</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck - butcher knife by wife during argument</b>							
20c. TIME OF INJURY Month, Day, Year <b>7:00 p.m. 10-22-1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>					
20f. (City or town) <b>Mr. Boonsboro</b> (County) <b>Wash.</b> (State) <b>MD.</b>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward W. Ditto, III</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22. DATE SIGNED <b>10-25-67</b>				22. DATE SIGNED <b>10-25-67</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rode Hill Cemetery</b>					
23d. LOCATION (City or Town) <b>Hagerstown</b> (County) <b>Wash Co</b> (State) <b>MD</b>											
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b>				25. REC'D BY REGISTRAR <b>Charles Judge</b>							
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
25c. DATE <b>OCT 30 1967</b>											
25d. ADDRESS <b>Andrew K. Coffman Funeral Home Inc.</b>											

1988

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

14594		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14604	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 30 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			d. STREET ADDRESS 2112 GAY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES THEODORE STROUSE			4. DATE OF DEATH Month Day Year OCTOBER 22 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1878	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED AGENT		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
13. FATHER'S NAME CHARLES R. STROUSE			14. MOTHER'S MAIDEN NAME MARY GLENTER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-10-4785		17. INFORMANT MECHANICSBURG PENNA. MRS. EDNA S. ANDREWS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic disease cerebral DUE TO (c) indef Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; pneumonitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9-24-64, 19 to 10-22-67, 19, that (I) (we) last saw the deceased alive on 10-21-67, 19, and that death occurred at 1:30 AM, from causes and on the date stated above.					
22a. SIGNATURE Robert F. Keadle, M.D.		22b. DATE SIGNED 10-24-67		22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M.D.	
22d. ADDRESS Hagerstown, Md 21740					
23a. BURIAL, CREMATION, REMOVAL, ETC. BURIAL		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.					
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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1-10-01

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# CERTIFICATE OF DEATH

14595

14605

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>455 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>				d. STREET ADDRESS <b>637 Lincoln Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys May SULLIVAN</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1886</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Brant</b>				14. MOTHER'S MAIDEN NAME <b>Elvira Deahl Leving Deahl</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Earl R. Sullivan Cumberland, Md. 21502</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis, general</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>(1) Diabetes Mellitus (2) Fracture of hip</b>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell when transferring to a couch (Medical Examiner notified &amp; body retained)</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:00 p.m.</b> <b>11/10/66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Allegany, Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>July 38, 1966</b> to <b>Oct. 26, 1967</b> , that (I) (we) saw the deceased alive on <b>October 26, 1967</b> , and that death occurred at <b>12:50 A</b> M, from causes and on the date stated above							
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Oct. 26, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>				22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-29-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>				ADDRESS <b>404 Decatur St. Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1887

CERTIFICATE OF DEATH

WASHINGTON

1887

455 days

Marshall

Marshall

637 Lincoln Street

Slays

Sullivan

Dec. 7, 1887

Oct. 26

Marshall

Marshall

Henry Grant

Marshall

Marshall

Diabetes Mellitus

Fall River, Massachusetts

1887

October 21

Home

July 28

Victor A. Brown, M.D.

Victor A. Brown, M.D.

Oct. 26

Marshall

Oct. 26

## CERTIFICATE OF DEATH

14596

14606

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Yarrowsburg</u>	
c. LENGTH OF STAY in 1b <u>21 days</u>		d. STREET ADDRESS <u>RFD #2 Knoxville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martha Naomi Sullivan</u>		4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1915</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR / IF UNDER 24 HRS. Months / Days / Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Weverton, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Albert Newton Deaner</u>		14. MOTHER'S MAIDEN NAME <u>Flora Virginia Kelbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-2613</u>	
17. INFORMANT <u>Paul A. Sullivan</u>		Address <u>RFD #2, Knoxville, Md. 21758</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Heart Failure</u> DUE TO (b) <u>Pulmonary Vascular Hypertension</u> DUE TO (c) <u>Pulmonary Fibrosis, chronic bronchitis, emphysema</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. / p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 9, 1967</u> , to <u>Oct 10, 1967</u> , that (I) (we) last saw the deceased alive at <u>4:00</u> 1967, and that death occurred at <u>4:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles C. Spencer</u>		22b. DATE SIGNED <u>10-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>		22d. ADDRESS <u>145 S. Prospect Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Heights</u>	23d. LOCATION (City or Town) (County) (State) <u>Brownsville, Md.</u>
24. FUNERAL DIRECTOR <u>Ronald Eables</u>		25a. REC'D BY REGISTRAR <u>Harpers Ferry, West Va.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14597 14607											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>131 S PROSPECT ST</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>M JOSEPHINE SWEENEY</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 14 1967</b>		5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>WASHINGTON COUNTY MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN B SWEENEY</b>					14. MOTHER'S MAIDEN NAME <b>SOPHIA J HURLEY</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>W. WARREN STULTZ HAGERSTOWN MARYLAND</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to anoxia of brain following</b> 9216 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>foreign body (piece of meat wedged in trachea.)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <b>34 hours</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Large piece of meat wedged in trachea.</b>								
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> p.m. <b>10-12- 19 67</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Restaurant</b>		20f. (City or town) (County) (State) <b>Hagerstown, Washington, Md.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										22. DATE SIGNED <b>10/16/67</b>	
ACTUAL SIGNATURE <b>E W DITTO JR.</b>			EXAMINER'S NAME (Type) <b>E W DITTO JR. M.D. 215 W WASHINGTON ST. HAGERSTOWN MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>10/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN WASHINGTON MD.</b>			
24. FUNERAL DIRECTOR <b>CHARLES M ROUZER</b>			ADDRESS <b>HAGERSTOWN MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

UNITED STATES MARSHAL SERVICE

OCT 18 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14598											
14608											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>427 W. Franklin St.</u>						d. STREET ADDRESS <u>427 W. Franklin St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Barry</u> Middle <u>Eugene</u> Last <u>Templon</u>						4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 5, 1967</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>23</u> Days <u>23</u> Hours <u>23</u> Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard M. Templon</u>						14. MOTHER'S MAIDEN NAME <u>Eva Jean Perrott</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. R. M. Templon 427 W. Franklin St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus and spina bifida</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>7512</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 5</u> , 19 <u>67</u> , to <u>Oct. 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept. 11</u> , 19 <u>67</u> , and that death occurred at <u>4A.</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>B. B. Kneisley</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>10/28/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>						22d. ADDRESS <u>148 West Washington St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>				
24. FUNERAL DIRECTOR <u>Wm. C. Hoff</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 31 1967</u>											

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>				d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SHERMAN STANLEY TOMS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 29, 1890</b>		9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shoe factory</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Sheridan Toms</b>				14. MOTHER'S MAIDEN NAME <b>Olivia Wolfe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>405-09-0560</b>		17. INFORMANT Address <b>Route 2</b> <b>Mrs. Ruth Easterday, Boonsboro, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOCLEROTIC HEART DISEASE</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 1/2.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 7, 1967</b> , to <b>OCTOBER 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 27, 1967</b> , and that death occurred at <b>4:45 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Domingo A. Garcia</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>October 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>DOMINGO A. GARCIA</b>				22d. ADDRESS <b>WESTERN MARYLAND STATE HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/29/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Pa.</b>	
24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

YOUNG, W. H. 1953. *Journal of the Royal Society of Medicine* 46: 101-102.

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2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

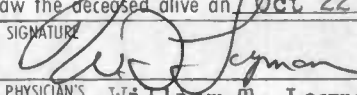
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## CERTIFICATE OF DEATH

14610

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>10-2</b>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>VIRGINIA</b> Last <b>VIRTS</b>		4. DATE OF DEATH Month <b>Oct</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 1, 1877</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Grim</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-48-6548</b>	
17. INFORMANT <b>Charles F. Virts</b>		Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Insufficiency</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>Oct 22</b> , 19 <b>67</b> , to <b>Oct 22</b> , 19 <b>67</b> , that (I) <del>we</del> saw the deceased alive on <b>Oct 22</b> , 19 <b>67</b> , and that death occurred at <b>2:55 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Oct 24, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Prof.Arts Bldg. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Knoxville Maryland</b>
24. FUNERAL DIRECTOR <b>Laurel Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 26 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FILE

NOV 11 1967

RECEIVED

2 days

AMERICAN COUNTY

WATER

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

14611

14601

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>FREDERICK</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>747 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont rural 10-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>			d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Iva</b> Middle <b>Susan</b> Last <b>Weddle</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>1967</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1892</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Hewitt</b>		
14. MOTHER'S MAIDEN NAME <b>Susan Sheets</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. <b>212-38-9717</b>			17. INFORMANT Glenn Weddle Frederick, Md. RD 7		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>lobular pneumonia</b> DUE TO (b) <b>cerebral thrombosis &amp; hemiplegia raphana</b> DUE TO (c) <b>arteriosclerosis, general</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 years</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 7, 1965</b> to <b>Oct. 24, 1967</b> , that (I) ( <del>we</del> ) saw the deceased alive on <b>Oct. 24, 1967</b> , and that death occurred at <b>7:25</b> M, from causes and on the date stated above					
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>				22b. DATE SIGNED <b>Oct. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>				22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lewistown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lewistown Fred. Co. Md</b>	
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>				25a. REC'D BY REGISTRAR <b>Oct 30 1967</b>	
ADDRESS <b>Thurmont, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles J. George</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11011

5034

RECEIVED

10/17/50

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY

FOR AFFAIRS OF THE UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

10/17/50

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY

FOR AFFAIRS OF THE UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

10/17/50

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY

FOR AFFAIRS OF THE UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14602  
CERTIFICATE OF DEATH  
14612

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>61 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1336 Salem Ave.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1336 Salem Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Jacob</b> Last <b>Weddle</b>				4. DATE OF DEATH Month <b>October</b> Day <b>24</b> , Year <b>1967</b>									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-13-88</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b>21</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Edgemont, Md.</b>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel Weddle</b>						14. MOTHER'S MAIDEN NAME <b>Jennie Wolfe</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>705-10-7766</b>		17. INFORMANT <b>Leroy Weddle, Hagerstown, Md.</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Unknown</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 mins.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Podagra</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 23</b> , 19 <b>67</b> , to <b>Oct 24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct 23</b> , 19 <b>67</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>W. T. Layman</b> 22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>										22b. DATE SIGNED <b>Oct 25, 1967</b>			
22d. ADDRESS <b>100 Prof. Arts Bldg. Hagerstown, Md</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>10-27-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>					
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14613

f. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 wks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>231 W. North St.</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Clinton Wetzel</b>		4. DATE OF DEATH Month <b>10-</b> Day <b>13-</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	9. AGE (In years last birthday) yrs. <b>73</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William O. Wetzel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Gossard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>207-30-5455</b>	
17. INFORMANT <b>Mrs. Charles C. Wetzel Sr.</b>		Address <b>Waynesboro, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distractions and liver alien</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>chronic obstructive + cholesterol</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>cutaneous heart disease</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Eunice Schuman</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/16/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Franklin, Pa.</b>
24. FUNERAL DIRECTOR <b>Walter G. Goss</b>		25a. REC'D BY REGISTRAR <b>OCT 19 1967</b>	
ADDRESS <b>Waynesboro, Penna.</b>		25b. REGISTRAR'S SIGNATURE <b>Richard J. Goss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14608

RECEIVED IN CHARGE

1941

Washington

Washington

2 days

Washington

Washington Co. Hospital

Washington Co. Hospital

Washington Co. Hospital

Washington

Male

Feb. 22, 1941

U.S. Post Office

U.S. Post Office

Franklin Co., Tenn.

U.S.A.

William O. Brown

Harry Allen (Howard)

no

207-10-105

Franklin Co., Tenn.

Washington

Franklin Co.

10/20/1941

Franklin

Washington, Tenn.

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Washington, Tenn.

Franklin

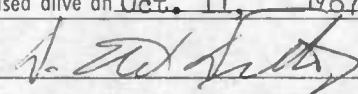
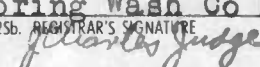
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

14604

CERTIFICATE OF DEATH

14614

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>7 1/2 Hrs</b>		d. STREET ADDRESS <b>19 West Washington St</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BESSIE VIOLA WIDMYER</b>		4. DATE OF DEATH Month Day Year <b>Oct 12 1967 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3 1889</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md. Clear Spring Wash Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jerry Trumppower</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Kinsell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8863</b>	
17. INFORMANT <b>Mrs Helen Earley</b>		Address <b>54 No Cannon Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 11, 1967</b> , to <b>Oct. 12, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 11, 1967</b> , and that death occurred at <b>2 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>10-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>near Clear Spring Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Cogfman</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 16 1967</b>	
25b. REGISTRAR'S SIGNATURE 			

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RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14605

CERTIFICATE OF DEATH

14615

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN RT.#5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WATER ST. LEITERSBURG</b>				d. STREET ADDRESS <b>WATER ST. LEITERSBURG</b>			
3. NAME OF DECEASED (Type or print) <b>ELVA MAY WILHIDE</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>13</b> Year <b>1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 10 1888</b>		9. AGE (In years lost birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN H. HOVIS</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE HURD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>177-24-7214</b>		17. INFORMANT <b>MR. WALTER F. BARNHART</b>		Address <b>RT#5 HAGERSTOWN MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO <b>Arteriosclerotic Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 yrs.</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>68</b> , to <b>10-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-2</b> , 19 <b>67</b> , and that death occurred at <b>6:00 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Charles F. Hess</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES F. HESS M.D.</b>				22d. ADDRESS <b>SMITHSBURG, MD.</b>			
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEITERSBURG LUTHERN</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON CO. MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Korman, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14608

WASHINGTON

MARYLAND

HAGERSTOWN

2 WEEKS

WASHINGTON COUNTY HOSPITAL

HERMAN

ELWOOD

YOUNKER

MALE

WHITE

WIDOWED

DIVORCED

3/31/1913

54

WASHINGTON CO., MD.

U.S.A.

HARRY CLEATUS YOUNKER

LULA LOUISE MOORE

NO

RANSY M. YOUNKER RFD #2, HANCOCK, MD.

151X

adenocarcinoma of stomach with disseminated

metastasis

13 mos.

none

10-31-67

8:05 PM

John H. Kehne, M.D.

11-2-67

11/3/1967

PARKHEAD E.U.B.

WASHINGTON COUNTY, MD.

HOWARD J GROVE

HANCOCK, MARYLAND

NOV 6 1967

Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14616

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>2 WEEKS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b> d. STREET ADDRESS <b>RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERMAN ELWOOD YOUNKER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1913</b>
9. AGE (In years lost birthday) yrs. <b>54</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY CLEATUS YOUNKER</b>		14. MOTHER'S MAIDEN NAME <b>LULA LOUISE MOORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>RANSY M. YOUNKER RFD #2, HANCOCK, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>10 adenocarcinoma of stomach with disseminated</b> DUE TO <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>13 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-3-66</b> , 19____ to <b>10-31-67</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-31-67</b> , 19____, and that death occurred at <b>8:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Kehne</b>		22b. DATE SIGNED <b>11-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Kehne, M.D.</b>		22d. ADDRESS <b>1229 Ravenwood Heights, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/3/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKHEAD E.U.B.</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON COUNTY, MD.</b>
24. FUNERAL DIRECTOR <b>HOWARD J GROVE</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
ADDRESS <b>HANCOCK, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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RURAL HANCOCK

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MARYLAND

HARRINGTON COUNTY HOSPITAL

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YOUNG

OCTOBER

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MALE WHITE

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WASHINGTON CO., MD. U.S.A.

HAGGETT

HARRY CLAYTON YUNKER

LULA LOUISE MOORE

PAWBY A. YUNKER AND S. HANCOCK, MD.

1) anemomorphosis of stomach with characteristic

metastasis

1. 1919

1919

10-1-19

10-1-19

10-1-19

10-1-19

11-1-19

1919 Haverwood Heights, Haverwood, Pa.

John H. Kerner, M.D.

PARKHEAD E.U.C.

BURIAL

WASHINGTON COUNTY, MD.

HANCOCK, MARYLAND

FORWARD 4 GROVE